Subpart A—General Provisions

SOURCE: 63 FR 35068, June 26, 1998, unless otherwise noted.

§ 422.1 Basis and scope.

(a) *Basis.* This part is based on the indicated provisions of the following sections of the Act:

1851—Eligibility, election, and enrollment.
1852—Benefits and beneficiary protections.
1853—Payments to Medicare Advantage (MA) organizations.
1854—Premiums.
1855—Organization, licensure, and solvency of MA organizations.
1856—Standards.
1857—Contract requirements.
1858—Special rules for MA Regional Plans.
1859—Definitions; enrollment restriction for certain MA plans.

(b) *Scope.* This part establishes standards and sets forth the requirements, limitations, and procedures for Medicare services furnished, or paid for, by Medicare Advantage organizations through Medicare Advantage plans.

[63 FR 35068, June 26, 1998, as amended at 70 FR 4714, Jan. 28, 2005]

§ 422.2 Definitions.

As used in this part—

Arrangement means a written agreement between an MA organization and a provider or provider network, under which—

(1) The provider or provider network agrees to furnish for a specific MA plan(s) specified services to the organization's MA enrollees;

(2) The organization retains responsibilities for the services; and

(3) Medicare payment to the organization discharges the enrollee's obligation to pay for the services.

Balance billing generally refers to an amount billed by a provider that represents the difference between the amount the provider charges an individual for a service and the sum of the amount the individual's health insurer (for example, the original Medicare program) will pay for the service plus any cost-sharing by the individual.

Basic benefits means all Medicare-covered benefits (except hospice services).

Benefits means health care services that are intended to maintain or improve the health status of enrollees, for which the MA organization incurs a cost or liability under an MA plan (not solely an administrative processing cost). Benefits are submitted and approved through the annual bidding process.

Coinsurance is a fixed percentage of the total amount paid for a health care service that can be charged to an MA enrollee on a per-service basis.

Copayment is a fixed amount that can be charged to an MA plan enrollee on a per-service basis.

Cost-sharing includes deductibles, coinsurance, and copayments.

Downstream entity means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

First tier entity means any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

Institutionalized means for the purpose of defining a special needs individual, an MA eligible individual who continuously resides or is expected to continuously reside for 90 days or longer in a long-term care facility which is a skilled nursing facility (SNF) nursing facility (NF); SNF/NF; an intermediate care facility for the mentally retarded (ICF/MR); or an inpatient psychiatric facility.

Institutionalized-equivalent means for the purpose of defining a special needs individual, an MA eligible individual who is living in the community but requires an institutional level of care. The determination that the individual requires an institutional level of care (LOC) must be made by—

(1) The use of a State assessment tool from the State in which the individual resides; and